



FORUM SESSION

Payers and Patients: Searching for Value

JULY 12, 2013

THE VALUE EQUATION

Value, as used in current health policy discussions, is shorthand for good quality at a lower cost. It might mean a specified level of quality at a lesser cost, or better quality at a specified cost, but the general idea is that purchasers are looking for a better deal.

Health plans are striving to offer, and plan sponsors and consumers are eager to buy, insurance coverage that manifests value. Providers are under pressure to demonstrate that they can deliver value. All sorts of agencies, from the U.S. Department of Health and Human Services to local business coalitions on health, are engaged in measuring value. And the stakes are growing. Measurement and reporting requirements with associated rewards and penalties were expanded and refined by the Patient Protection and Affordable Care Act of 2010. Health plans use a variety of measures to develop and sell tiered networks and other value-based products.

Consensus on how value may be recognized and measured has not emerged. As Steven Brill illustrated in his widely read analysis for *Time*, it can be immensely frustrating to figure out what cost to associate with a given health care service. There is the ostensible charge, what a particular insurer will pay in or out of network, the amount for which the patient can be balance billed, and so on. Insurers and providers are unlikely to make public the rates that they have negotiated. Most patients do not know what their financial responsibility will be until a bill arrives. Even if these various “costs” were known with certainty, the discrepancy between the patient’s and the insurer’s cost may make the value calculation very different—although neither may feel they are getting the best deal.

National Health Policy Forum

2131 K Street, NW
Suite 500
Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

Judith Miller Jones
Director

Sally Coberly, PhD
Deputy Director

Monique Martineau
*Director, Publications and
Online Communications*

Forum Session Manager

Lisa Sprague
Principal Policy Analyst

The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.

So the cost element of the value equation is murky. Unfortunately, the quality piece is by no means crystal clear either. The purposes, measures, data sources, and effects of quality measurement vary considerably.

Quality can be defined in terms of adherence to evidence-based protocols, patient/family goals or satisfaction, or patient outcomes. But even with agreement on the dimension, it remains difficult to pin down. Evidence may change over time. Satisfaction is a subjective thing, even if measured on a point scale. Outcomes depend, in part, on factors beyond the control of the provider. An entity desiring to measure provider performance must make choices among or construct some amalgam of these dimensions.

Such choices are influenced by the organization's technical sophistication, the availability and ease of collecting data, and even the primary purpose of quality measurement. Information arrayed to help consumers make choices will not be the same as that generated by a medical practice to support its physicians' quality improvement initiatives.

A plethora of quality measures is available from a variety of sources. These include, for example, public-sector organizations (such as AHRQ, the Agency for Health Research and Quality), private nonprofits (such as NCQA, the National Committee for Quality Assurance), private for-profits (Healthgrades), or professional societies. Some of the measures developed by these groups are in the public domain; others have been kept proprietary.

The National Quality Forum (NQF), a membership organization of health care stakeholders, was created to build consensus on national priorities and goals; to establish national consensus standards; and to review, endorse, and recommend the use of standardized quality measures. Measures submitted for NQF approval are subject to a rigorous, public, consensus-based validation process. At the time of writing, 688 endorsed measures were offered on the NQF website. However, there is no requirement that a measure must be NQF-endorsed in order to be used in the marketplace.

A wealth of measures to choose from does not necessarily add up to a complete picture of the quality of care being provided by a clinician or facility. Some courses of treatment may be adequately reflected by a handful of measures; others are more complicated. As Robert Berenson, Peter Pronovost, and Harlan Krumholz point out in a May 2013 paper, basing quality scores on measures that may account for a

small portion of an internist's activities does not yield a meaningful assessment of quality.¹ Providers may rightly feel that being assessed on a handful of selected measures may have little bearing on overall patient care quality. Some organizations have instituted bundled measures for certain conditions, such as all the tasks that, taken together, make for good diabetes or cardiac care. So far there is no composite measure of quality across conditions or across a practice. Moreover, there are activities that most people would call integral to quality that are beyond current measurement capacity, such as whether a diagnosis is accurate or whether the patient's care setting has any degree of the "systemness" that tends to be associated with better coordinated care.

Standardization is a major theme in quality measurement. Providers complain that different measuring entities have different definitions or want differently structured data. Patrick Conway and colleagues, writing in the *Journal of the American Medical Association*, call for a more "parsimonious" set of standardized core measures common to all.² Some analysts have suggested that providers should be asked to submit aggregate data that the measuring entities could then subdivide or structure as best suits their needs.

Pay-for-performance programs have proliferated over the past decade and already affect most providers to at least some degree. Research has shown numerous examples of positive behavior change related to performance incentives and performance reporting, though the end results are often (again) ambiguous. In a widely cited example, hospitals in CMS's multi-year Premier Hospital Quality Incentive Demonstration produced higher scores than comparison hospitals on what were mostly process measures, but failed to achieve reduced mortality for their patients.³ A study of the effect of public reporting on certain Wisconsin physician groups found that quality improved on the publicly reported measures, but not necessarily on associated measures that were not reported.⁴

Since the inception of pay-for-performance programs tied to quality measurement, providers have expressed doubts as to measurement methodology, particularly with respect to risk adjustment (as in making claims that "my patients are sicker"). Berenson *et al.* note that risk-adjustment methodology has improved over the years, but that its application has yet to be standardized.⁵

Quality measurement and reporting aimed at influencing consumer choice remains more optimistic than effectual. While information comparing hospitals is widely available, consumers tend to rely on



perceptions related to a hospital's reputation and medical services, AHRQ reports.⁶ They also rely on their physicians to direct them to a particular institution. Ratings of physicians are available from Healthgrades and similar services available on the Internet, but patients are more likely to allow their existing physicians to guide them, or to consult friends and family. Calls for patient engagement in health care most frequently invoke shared decision-making with one's doctors, but also involve using available information to make informed choices among them.

MOVING FORWARD

Given the ambiguities just described in both elements of the value equation, it is not surprising that measures of value itself are hard to come by. Those that do exist, such as the value-based payment modifier (VBM) applied to physician performance by the Centers for Medicare & Medicaid Services (CMS), are still experimental. The VBM is a mechanism for paying physicians differentially on the basis of the quality and cost of their care, as reported via Medicare's Physician Quality Reporting System. Using quality and cost data reported for 2013, differential payment is scheduled to begin in 2015.

In spite of widespread dissatisfaction with the current state of measurement, reporting, and value-based purchasing, there is equally widespread agreement that value is a worthy pursuit. Better quality and lower (or at least less steeply rising) costs are hard to argue with. A combination of methodological improvement, acceptance of accountability, and incentive alignment is likely key to further progress.

SESSION

David Lansky, PhD, president and chief executive officer of the Pacific Business Group on Health, discussed the development of the value-based purchasing concept, what kind of progress is being made, and what decisions remain to be grappled with by purchasers, providers, consumers, and policymakers. Reactions were offered by **Andrew Baskin, MD**, national medical director for quality and provider performance measurement with Aetna, a company long involved in payment reform efforts, and **Michael Pramenko, MD**, a family physician, executive director of Primary Care Partners in Grand Junction, Colorado, and former president of the Colorado Medical Society.

KEY QUESTIONS

- To what extent can value calculations be made in health care today? What further research is needed in methodologies for measuring quality, costs, and value itself?
- Do the necessary data exist? To what extent are they readily available? What changes are being made to give both decision-makers and researchers access to such data?
- What are employers who sponsor health plans and insurance companies who administer them doing to steer employees to high-value providers?
- What are providers doing to demonstrate quality and efficiency to purchasers?

ENDNOTES

1. Robert A. Berenson, Peter J. Pronovost, and Harlan M. Krumholz, "Achieving the Potential of Health Care Performance Measures," Robert Wood Johnson Foundation and Urban Institute, May 2013, p. 7, available at www.rwjf.org/en/research-publications/find-rwjf-research/2013/05/achieving-the-potential-of-health-care-performance-measures.html.
2. Patrick H. Conway, Farzad Mostashari, and Carolyn Clancy, "The Future of Quality Measurement for Improvement and Accountability," *Journal of the American Medical Association*, 309, no. 21 (June 5, 2013): p. 2215, available at <http://jama.jamanetwork.com/article.aspx?articleid=1693896>.
3. Ashish K. Jha *et al.*, "The Long-Term Effect of Premier Pay for Performance on Patient Outcomes," *New England Journal of Medicine*, 366 (April 26, 2012): pp. 1606-1615, available at www.nejm.org/doi/full/10.1056/NEJMs1112351.
4. Geoffrey C. Lamb *et al.*, "Publicly Reported Quality-of-Care Measures Influenced Wisconsin Physician Groups to Improve Performance," *Health Affairs*, 32, no. 3 (March 2013): p. 540, available at <http://content.healthaffairs.org/content/32/3/536.short>.
5. Berenson, Pronovost, and Krumholz, "Achieving the Potential," p. 11.
6. Agency for Healthcare Research and Quality, "Perceived reputation and other factors influence consumers' hospital choices," Research Activities, No. 383, July 2012, available at www.ahrq.gov/news/newsletters/research-activities/jul12/0712RA8.html.